DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility failed to provide meals within reach to maintain dignity for 1 of 5 sampled residents (Resident #7) reviewed for dignity. Findings included: Resident #7 was admitted to the facility on 8/17/11 and had a diagnosis of dementia and anxiety. A nurse's note dated 2/21/13 indicated that when a staff member attempted to feed Resident #7, the resident clamped her lips together and refused to eat. The nurse's notes dated 2/25/13 - 3/4/13 indicated daily that the resident was a "self feeder after tray set up." The resident's Minimum Data Set (MDS), dated 2/25/13, indicated the resident had a severe cognitive impairment, did not reject care, and did not have physical, verbal, or other behavioral symptoms directed toward others. Her functional status indicated that she required limited assistance and one person physical assist with eating. She had no swallowing disorders.	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 241 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – Resident # 7 was assessed on 04/11/2013 by the Director of Nursing for meal delivery and her intake. Resident refused any staff assistance with eating. Resident proceeded to try	4/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5-6-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 The nutrition assessment note dated 2/26/13 indicated that the resident was alert, needed limited assistance with feeding, was on a regular diet, ate 75-100% of most meals, and was at low nutrition risk. A care plan note dated 3/5/13 indicated that a meeting was held and included the Assistant Director of Nursing, Activities Assistant #1, and the Dietary Manager. The note stated, "No change to plan of care. Continue with current plan." There was no mention in the care plan note regarding any behaviors, including during meals. A review of the resident's current care plan on 3/26/13 indicated the care area "Inability to complete activities of daily living (ADL) tasks independently related to cognitive impairment" was last reviewed on 2/26/13. The goals were measureable and interventions included provide meal set up and encourage the resident to consume foods and fluids. A review of the resident's weight indicated that she had no weight loss in the last 90 days. On 3/26/13 at 8:25am, 3 residents were sitting in the sunroom eating breakfast. There were no staff members present. Resident #7 was sitting at the end of the table. Her plate was sitting in front of her and contained partially eaten food and a fork. The resident was observed independently eating, but there were no fluids in front of her. She reached over, picked up the cup belonging to the resident sitting to her left and drank water from her cup. She drank without any difficulty, did	F 241	to play with her different foods and drinks that were in front of her. Resident attempted several times to pour her liquid drinks either onto the table or into her food items. A Certified Nursing Assistant will be assigned to the Mauve 1 dayroom to supervise resident # 7 with her meals. Certified Nursing Assistants will be in-serviced by the Staff Development Coordinator regarding resident's dignity and meal delivery for resident #7 and any other resident requiring assistance. This in- service training was completed on 04/17/2013. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – All residents currently in house have been assessed for requiring this meal delivery method and no other residents have the same or similar practice. All Certified	4/19/13

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F 241	Continued From page 2 not spill the fluid, and did not pour it into her plate. Her tray was observed on top of the chest of drawers at the side of the room, approximately 8 feet from the resident. It contained the resident's meal card, full cup of coffee, full cup of water, unopened chocolate milk, spoon, and napkin. The card indicated a regular diet with beverages of coffee, juice, and chocolate milk. On 3/26/13 at 8:36am Nurse #1 entered the sun room. When asked about the assistance that the residents in the sunroom needed with meals she stated, "There are no particular residents that we bring in here. We just bring some in here. We set up their trays and come back to check on them. We do a lot of encouraging." She indicated the 3 residents in the room usually eat together. On 3/26/13 at 8:40am Nurse #1 called Nursing Assistant (NA) #1, from the hallway, to assist Resident #7. The resident complained to the NA about the sun in her eyes. The NA stated, "Let's eat." The NA went to the resident's tray on the chest of drawers, got her milk, opened it, and stated to the resident, "Here, I can't find no straw." She sat beside the resident but did not assist further with her meal. When asked why the resident's tray with her fluids was on the chest of drawers the NA stated, "Sometimes she will make a mess so we put her tray over there and give her a little at a time." At 8:44 am the NA removed the resident's plate, placed in on the tray at the side of the room, left the water that the resident had been drinking, that belonged to the resident to her left, and the chocolate milk on the table in front of Resident #7. On 3/26/13 at 8:50am the Director of Nursing	F 241	Nursing Assistants were in-serviced regarding resident's dignity and meal delivery by the Unit Manager and Staff Development Coordinator to be completed on 04/17/2013. All new Certified Nursing Assistant hires will be trained during new hire orientation regarding resident's dignity and meal delivery by the Staff Development Coordinator. A 10% audit will be completed to ensure no other resident receives this meal delivery method weekly for four weeks than monthly for two months. Results of the audits will go to weekly Quality Assurance/Risk Meetings for four weeks and also to the next quarterly Quality Assurance Meeting.	4/19/13

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F 241	Continued From page 3 (DON) was interviewed and indicated that the dining in the sunroom was "not necessarily assisted dining", and that the residents were placed in there if they are not able to tolerate the stimulating environment of the main dining and may need some assistance. She further stated that all residents should have their food and fluids placed in front of them at meal times. On 3/26/13 at 12:45pm there were 6 residents eating lunch in the sunroom. Resident #7 was sitting at the table. Nurse #1 placed the resident's bowl of food and her cup of tea with a straw in front of her. Her tray contained slaw, pudding, chocolate milk, and water and was placed on the chest of drawers at the side wall of the room, approximately 8 feet away from Resident #7. On 3/27/13 at 12:39pm Resident #7 was observed sitting in the sunroom eating lunch with 6 other residents. She was sitting at the end of the table, holding and eating a sandwich. Her place at the table in front her was empty. The resident's tray was on top of the chest of drawers along the side wall of the room, about 8 feet away from the resident, and contained a full cup of water, unopened chocolate milk, full cup of tea, pie, utensils, 2 covered bowls containing food that had not been eaten, and unopened vanilla shake. There was one nurse in the room, assisting another resident with her meal. At 12:40pm Resident #7 reached out and picked up the cup of tea off of another resident's tray. The nurse told her that was not her drink, got the resident's vanilla shake off of her tray at the side of the room, put a straw it, and gave it to the resident. The resident was observed eating her sandwich and drinking her vanilla shake independently and	F 241	**Measures to be put in place or systemic changes made to ensure practice will not re-occur** – All Certified Nursing Assistants were in-serviced regarding resident's dignity and meal delivery by the Unit Manager and Staff Development Coordinator to be completed on 04/17/2013. All new Certified Nursing Assistant hires will be trained during new hire orientation regarding resident's dignity and meal delivery by the Staff Development Coordinator. A 10% audit will be completed to ensure no other resident receives this meal delivery method weekly for four weeks than monthly for two months. Results of the audits will go to weekly Quality Assurance/Risk	4/19/13

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F 241	Continued From page 4 without difficulty, picking up the carton, drinking, and putting it down without spilling or pouring it out. There was no food or fluid observed on the resident, under or beside her wheelchair. At 12:49pm the nurse gave the resident a bowl of butter beans from her tray at the side of the room. A spoon was placed in the bowl and the resident ate independently and without difficulty. She shook her carton of vanilla shake and stated "it is gone." The nurse got up and gave the resident her cup of tea. The resident drank her open-top cup of tea with a straw and did not spill it or mix it with her food. On 3/27/13 at 1:16pm the Assistant Director of Nursing (ADON) was interviewed regarding a reason why the resident would have her meal tray, including fluids, kept out of her reach. She stated, "No, there is no reason." The ADON indicated that she would try to find documentation as to why this is being done by staff. At 2:20pm the ADON indicated that she was unable to find documentation and stated the resident "does get very agitated if someone tries to feed her. She prefers to do it herself." A progress note by the DON on 3/27/13 at 2:44pm stated, "Resident plays in food/liquids at meal time. Staff gives resident one food/drink item at a time otherwise she will play with food and pour liquids into food and on table and not eat anything. Resident will not allow staff to assist with feeding or drinking. She will clamp mouth shut and/or push staff away. Resident has adequate intake and has not had a loss of weight or any signs or symptoms of dehydration. Will continue to monitor resident and encourage intake with items as they are given one by one.	F 241	Meetings for four weeks and also to the next quarterly Quality Assurance Meeting. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur** - A 10% audit will be completed to ensure no other resident receives this meal delivery method weekly for four weeks than monthly for two months. Results of the audits will go to weekly Quality Assurance/Risk Meetings for four weeks and also to the next quarterly Quality Assurance Meeting.	4/19/13

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F 241	Continued From page 5 Dietary sends food in bowls as requested." The resident's care plan with the problem area of inability to complete ADL tasks independently related to cognitive impairment was updated on 3/27/13 by the DON and stated, "Give resident one food and/or drink item at a time off of tray - resident will take liquid items and pour them over other food and on table. Resident will play in food/drinks." On 3/28/13 at 8:28am the resident was observed in the sunroom with 3 other residents. The 3 other residents had their meal trays in front of them and their meals were partially eaten. Resident #7 was sitting in her wheelchair with no food or fluids in front of her. The resident's tray was on a buffet at the end of the room, approximately 8 feet away from the resident. It contained a bowl of uneaten stewed apples, a bowl of partially eaten sausage gravy, unopened chocolate milk, uncovered cup of water that was full, and a cup that was full of coffee. NA#2 was assisting another resident. At 8:31am she gave Resident #7 the cup of water off her tray that was on the buffet. The resident drank all of the water and put the cup on another resident's tray. At 8:38am the NA took the bowl containing stewed apples and placed it in front of the resident. The resident began eating the apples independently. An interview was conducted with the ADON on 3/28/13 at 8:55am. When asked why the resident's food and fluids were not within her reach, she indicated that she changed the resident's care plan yesterday to reflect that the resident will mix her food and fluids and to give her one item at a time. She stated, "Dignity. It is	F 241		4/19/13

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F 241	Continued From page 6 what it is. I want the resident to eat and not lose weight or get dehydrated." She also indicated that she did not have documentation of the resident mixing her food and fluids.	F 241		4/19/13
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to: 1) appropriately maintain the kitchen's essential equipment (dishwashing machine and condensation hood filter); 2) ensure the kitchen's dishwashing drain was free and clear of debris and draining water appropriately; and 3) ensure the kitchen's floor and ceilings were kept clean in 1 of 1 kitchen. The findings include: 1. On 03/25/2013 at 12:00 a.m. an observation of the facility's kitchen dishwashing area was made with staff member # 1, the food service associate. The dishwasher observed to have a high pressure booster pump with metal cover located under the dishwasher area's clean side. The booster pump's metal top was observed to be rusted through exposing electrical wiring beneath it. The top also was observed to have had a previous repair where it had rusted through. The repair, using an auto repair bondo like substance appeared to have several areas that had broken off and were discolored where water had settled	F 465	F 465 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice** – The dishwasher high pressure booster pump was repaired using a new cover on March 25, 2013. The dishwasher vent filter was removed and cleaned on March 25, 2013. A replacement vent filter was installed on March 27, 2013. The dishwasher drain area was	

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F 465	Continued From page 7 on it. The observed rusted through areas had water marks on the metal indicating water from dish washer had splashed onto metal and was allowed to settle and rust. The dishwasher's main pump motor was observed directly under dishwasher. There were soap dispenser control wires lying loose across the motor. The motor and wires appeared to be rusting and had a white corrosive looking substance 6" long on them where wires were rubbing the motor. Staff member #1 indicated she was unaware how long the boost pump cover had been rusted through exposing the booster pump/wiring or how long the soap dispenser control wires had been lying across the washers main pump motor causing the rust and white corrosive looking substance. Also observed was the condensation hood above the dishwasher which was dripping water onto the floor, the dishwasher booster pump metal top, the prewash area and clean dish/post wash drain areas. The filter screen was observed to be rusted from edge to edge and had a black substance imbedded on and in the screens. The screen appeared to be broken and coming apart at the left edge as it was outside the bracket holder. Staff member #1 attempted to take the screen filter out of the holder for closer observation. The screen was broken to the point that it would not come out of the holder as the broken edges of the screen would catch the slide bracket it was sitting in. Staff member #1 indicated she had removed the screen 2 week prior but did not know when the last time the filter screen had been replaced and would have to get maintenance to remove the filter. Once the condensation filter screen was removed a closer observation was conducted. The multi-screen filter was broken apart and having 4 layers. Each	F 465	cleaned and free from debris on March 25, 2015. The kitchen ceiling and floors, walls, and ceilings were free of debris on March 25, 2013. **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice** – All dietary staff members were inserviced by the Dietary Manager on March 29, 2013 regarding the kitchen cleaning schedule and maintenance work order procedures. The dietary department has implemented a dietary department cleaning schedule that is audited three times per week by a dietary supervisor. Dietary equipment will be monitored for all potential maintenance service needs a minimum of three times weekly by a dietary supervisor.	4/19/13

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F 465	Continued From page 8 layer was observed to have rust, grease, and a black substance built up on the wire mesh/filer. Staff member #1 indicated that to her knowledge no one had ever submitted any work order sheets for any of the items observed and found in need of repair/replacement and she would put in work order sheets for the items. On 03/25/2013 at 1:10 p.m. an interview was conducted with the facility's dietary manager. The dietary manager indicated she did not know how long the dishwasher's boost pump metal cover had been rusted through and was unaware of the soap dispenser wires lying across the dishwasher's main pump were causing a rust line and white corrosive looking substance on the wires and motor. The dietary manager also indicated she was unaware the condensation hood filter screen was broken and had rust and a black substance on it. On 03/25/2013 at 2:57 p.m. an interview was conducted with the facility's maintenance director. The maintenance director indicated he was aware of the dishwasher's booster pump cover being rusted through for some time, having a previous repair, and needing to be replaced but was unaware of the soap control dispenser wires lying across the dishwasher's main motor causing a rust line and a white corrosive looking substance on the motor and wires. The maintenance director was asked to explain how facility staff identified items needing repair/replacement. The maintenance director indicated the staff would fill out a repair sheet and turn it into him. He would then fix and/or order parts and repair/replace the broken items. The maintenance director was asked if he could provide any maintenance repair	F 465	**Measures to be put in place or systemic changes made to ensure practice will not re-occur** – The Dietary supervisory staff will monitor the dietary department for any equipment in need of repair a minimum of three times weekly. The supervisory staff, along with other staff members, will submit work orders as needed to maintain the equipment in a safe and working condition. Audits will be conducted by the dietary supervisory staff and work orders will be submitted as needed. The dietary audits will be conducted to review both cleaning and equipment repair needs. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur**- Dietary audits will be reviewed weekly at the Risk meeting and as a part of the quarterly Quality Assessment meeting.	4/19/13

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F 465	Continued From page 9 sheets for any items needing repair and/or replacement in the facility's kitchen for review. The maintenance director indicated he had no work order sheets for anything in need of repair/replacement in the kitchen except the wet wall areas. 2) On 03/25/2013 at 12:00 a.m. an observation of the facility's kitchen dishwashing area was made with staff member # 1, the food service associate. The dishwasher room floor appeared wet and had standing water along the walls. Under the dishwasher the garbage disposal and washer drain areas were observed. Observed was an accumulation of garbage, trash, food debris, and standing water along the wall behind the dishwasher. There was torn up paper and a plastic cup that was observed to have water line marks on them to indicate they had been lying on the drain by the wall for some time. Staff member # 1 could not state how long the garbage, trash, food debris, and standing water had been lying on the drain and the surrounding area. On 03/25/2013 at 1:10 p.m. an interview was conducted with the facility's dietary manager. The dietary manager indicated she did not know how long the garbage, trash, food debris, and standing water had been lying on the dishwasher's drain and surrounding area. On 03/25/2013 at 2:57 p.m. an interview was conducted with the facility's maintenance director. The maintenance director indicated he was aware of the standing water in the kitchen's dishwasher area but was unaware of the garbage, trash, and food debris on the drain and the surrounding	F 465		4/19/13

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F 465	Continued From page 10 area. The maintenance director indicated he also knew the water was seeping though the wall behind the dishwasher. The maintenance director was asked to explain how facility staff identified items needing repair/replacement. The maintenance director indicated the staff would fill out a repair sheet and turn it into him. He would then fix and/or order parts and repair/replace the broken items. The maintenance director was asked if he could provide any maintenance repair sheets for any items needing repair and/or replacement in the facility's kitchen for review. The maintenance director indicated he had no work order sheets for anything in need of repair/replacement in the kitchen except the wet wall areas. 3) On 03/26/2013 at 12:00 a.m. an observation of the facility's kitchen dishwashing area was made with staff member # 1. The white ceiling above the dishwasher pre-wash area and above a wall mounted fan next to the dishwasher was observed to have a black substance growing on the ceiling from wall corner to wall corner across the ceiling (the length of the wall). Staff member #1 could not state how long the black substance had been on the ceiling or when the last time the ceiling had been cleaned. The floor and tiles in the dishwasher room/area were also observed. There was standing water on the floor throughout the room which appeared to go under and/or through the walls. The grout between the floor tiles around the dishwasher and several other area of the dishwasher room were observed to have a black substance growing on the tan grout between the floor tiles. Staff member #1 poured bleach on several of the grout areas observed with the black substance on the grout. The	F 465		4/19/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 11 bleach immediately dissolved the black substance. Staff member #1 indicated the floors were pressure washed twice yearly and were to be done next month (April 2013). On 03/25/2013 at 1:10 p.m. an interview was conducted with the facility's dietary manager. The dietary manager indicated she was not aware of the black substance growing on the ceiling in the dishwasher room or on the grout between the floor tiles. On 03/25/2013 at 2:57 p.m. an interview was conducted with the facility's maintenance director. The maintenance director indicated he was aware of the standing water in the kitchen's dishwasher area but was unaware of the garbage, trash, and food debris on the drain and the surrounding area. The maintenance director indicated he also knew the water was seeping though the wall behind the dishwasher. The maintenance director was asked to explain how facility staff identified items needing repair/replacement. The maintenance director indicated the staff would fill out a repair sheet and turn it into him. He would then fix and/or order parts and repair/replace the broken items. The maintenance director was asked if he could provide any maintenance repair sheets for any items needing repair and/or replacement in the facility's kitchen for review. The maintenance director indicated he had no work order sheets for anything in need of repair/replacement in the kitchen except the wet wall areas.	F 465		4/19/13